Description

From Discomfort to Courage: Challenging Racism

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Summary

Midwifery education promotes person centred care, but education around equity and anti-racist practice is often limited.[1,2] As a result, students are often unequipped with the necessary knowledge to recognise and professionally challenge racism in maternity care settings.[2] Students and registered midwives are often unprepared for the discomfort that comes with bearing witness to racism, bias, stereotyping or dismissive practice.[1] Yet the likelihood of encountering this remains high within large, complex healthcare systems where longstanding practices continue to perpetuate inequity.[3] This article explores how discomfort and hierarchy can lead to silence, even when care feels unsafe or unfair. It highlights how racism can present subtly through language, assumptions and decision making.[1] Emotional safety is considered along with the toll of speaking up, and it provides guidance to support students to act with morality when bearing witness to racism in all its forms.



Introduction: Discomfort in practice

Most student midwives can recall a moment in placement when something did not feel quite right. This may have involved:

- Witnessing dismissive or minimising responses when a person of colour raises a concern.
- Witnessing dismissive tones when someone of colour raised a concern.
- Assumptions made around family background, pain tolerance or ability to understand information, for example, the common yet false claim that Black people have higher pain thresholds.
- Black and Brown people being described as though they are a monolith.
- Encountering the voicing of harmful, biological myths around pelvic structure, skin thickness and less sensitive nerve endings in Black people.
- Observing decision making that has been influenced by bias.

This rarely looks like one dramatic incident and more often is a form of small interactions, underpinned by covert messaging. Racism in maternity care is rarely overt, and usually rears its head through bias, stereotyping and unequitable responses that are normalised in every-day care.[1]

When this is witnessed, the feeling of discomfort generally arrives before clarity. Student midwives and other health care professionals may feel unsettled, unsure or guilty for noticing what others seem to often overlook. They may question:

Am I misreading this? Is it my place to say anything? If I speak up, could it impact my placement?

Discomfort is natural. It is not a personal failing. It is often the first sign that something is wrong, needs closer attention, and that inequity may be evolving in front of you in real time.

The education gap

Midwifery education promotes person-centred care, yet racial literacy and cultural safety are inconsistently embedded within the midwifery curriculum.[4] Many midwives qualify without thorough education on how racism operates across a spectrum, and how this contributes to racial disparities in maternity care.[4]

Evidence shows that Whiteness remains the normative standard within midwifery education. This results in midwives lacking confidence in recognising clinical signs on Black and Brown skin tones, such as jaundice, cyanosis and pallor.[5,6] This is a typical example of institutionalised racism, where gaps in knowledge persist around signs and symptoms in people with melanated skin.

Structural racism is further upheld by the survival of nineteenth century biological myths in medical literature. Harmful concepts, such as the false 'African pelvis' classification, and common ideas such as Black individuals having physically thicker skin, continued to linger on library shelves and were only removed from modern education in recent years.[7,8,9] Despite removal from modern print, these biological myths, first constructed during the Transatlantic Slave Trade to justify the dehumanisation of Black people, still echo through healthcare today.[8,9] This continues to shape the clinical experiences of Black and Brown birthing people today, and the significant disparities in outcomes they face.[1,6]

The culture of silence

Recognising racism in all its forms in practice requires awareness. Those attuned to this can witness inequity and understand its impact on the lived experience of families and colleagues of colour. Common harmful and refuted examples include assumptions around Asian birthing people having lower pain thresholds, Black people having higher pain thresholds, and beliefs that Black people have physically thicker skin, and are more difficult to cannulate.[6] For students of colour, these concepts are personal and exhausting. They do not only recognise racism. They feel it. At the same time, students of colour often face additional barriers to raising concerns that can expose them to micro-aggressive labels and judgements, increasing vulnerability and making silence feel safer.[1] Racism and inequity are not always intentional, but the impact occurs, nevertheless. Too often intention is prioritised over harm and when intention is centred, the real harm experienced by people of colour is minimised, allowing inequity to persist unchallenged.[10,11,12]

Racism and bias thrive in silence. Even with awareness of that fact, discomfort often is the main barrier to speak up or act. Fear of being wrong, hierarchy imbalance, or anxieties around assessment and progression can make speaking up feel risky.[13] Recognising this is the first step, and with reflection and practical steps, students can learn to act thoughtfully, through balancing emotional safety with the responsibility to challenge inequity.

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Proactive professional challenge

Developing the ability to professionally challenge harmful comments, assumptions or decisions is a core part of a midwife's duty of care, fully aligned with the Nursing and Midwifery Council's (NMC) Code expectations to preserve safety, uphold dignity and challenge discriminatory behaviour.[14] Crucially, this responsibility applies to students as well as registered healthcare professionals. Being in training does not remove the obligation to act when harm or inequity occurs. Professional challenge does not require delivering a corrective lecture or even offering a full explanation; in practice, the most effective intervention is often a concise, well timed interruption that signals a need for reconsideration and creates space for reflective thinking.

These interruptions can take the form of:

- **Inviting someone to repeat their statement:** People often hear their own words differently the second time, and the act of repeating a statement can expose assumptions, highlight bias or make the impact of a comment more

apparent.

- **Requesting evidence for a claim or posing a clarifying question:** Many racialised beliefs in healthcare are not evidence based; they originate from outdated pseudoscience or inherited myths rather than clinical fact. When someone is unable to produce evidence for a claim, the pause that follows often creates a moment for reflection, either in the moment or longer term. That moment matters. This is an opportunity to interrupt automatic, biased thinking, and highlights that the comment did not come from credible knowledge. This form of intervention encourages individuals to reconsider the validity of what they have said. Interruptions like this disrupt bias, make the impact of a comment visible and promote reflective practice without escalation.
- **Redirecting to professional standards or evidence:** Returning the conversation to the NMC Code or clinical evidence shifts focus from opinion to professional accountability. This reinforces shared standards and supports safe, equitable practice.
- **Naming the potential impact:** Briefly acknowledge how a comment might be interpreted, for example, noting that it could impact trust or safety. This shifts attention to impact rather than intent, and signals that harm is possible, prompting reconsideration without confrontation.
- **Slowing the moment down:** Pausing the interaction to think through a decision or comment can interrupt automatic responses. This is particularly useful when assumptions are influencing clinical judgement or when decisions are being made quickly.
- **Offering an alternative perspective:** Introducing a different viewpoint can interrupt biased assumptions in a measured way. Providing an alternative explanation or reframing the situation encourages colleagues to think more critically about their assumptions.

The necessity of escalation

Professional challenge is important, but it is not the end of the process. Whether a student has been able to interrupt or challenge in the moment or not, escalation is always required when harm, discriminatory behaviour, or unsafe practice has occurred. This is not optional and is explicitly aligned with the NMC Code's requirements.[14]

For students, escalation is a professional responsibility, not an act of disloyalty or conflict. Being in training does not remove the obligation to act. The Code applies equally to students and registrants. Escalation demonstrates professional judgement, commitment to safe and equitable care and an understanding that safeguarding service users and colleagues requires both immediate interruption and formal reporting.

This expectation is further strengthened by the new NHS standards for tackling racism, which position the identification and reporting of discriminatory behaviour as a core responsibility for all staff, including students.[15] These standards emphasise that racism is both a patient safety issue and a workforce wellbeing issue, making timely escalation even more relevant students.[15]

Escalation matters because individual interruptions alone cannot address the wider institutional and behavioural issues that allow inequity to persist. A single moment of challenge may prompt reflection, but it does not ensure sustainable accountability, learning or change across the workforce. Escalation ensures that concerns are documented, patterns identified and appropriate support or corrective action can be taken. It should also protect students; raising concerns through formal channels shifts responsibility to the organisation, rather than leaving the burden solely on the individual who witnessed or received the harm. In doing so, students contribute to a culture where discriminatory behaviour is not only challenged in the moment but also addressed at organisational level. **TSM**

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